Electrical Industry Insurance Benefit Trust Fund of Alberta
4211 – 95 Street NW, Edmonton, Alberta T6E 5R6
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Fax: (780) 465-0808 Email: claims@ebfa.ca

# Supplementary Health Expense -
Supplies & Equipment

## Section 1 – To Be Completed By The Plan Member

**Plan Policy Number:** 6012

Plan Member – Last Name, First Name and Initial: EBFA Stakeholder Number:

Address: City: Province: Postal Code: Telephone Number:

Cell Phone Number: Birthdate (dd/mm/yy): Gender: ☐ Male ☐ Female

Nature of Illness: Custom Made Item: ☐ Yes ☐ No

## Claimant Information:

| Patient Name: | Date of Birth (dd/mm/yy): | Relationship to Plan Member: |
|---|---|---|
| | | |

## Co-insurance Information

**Do you or your dependents have any other coverage for the expenses being claimed on this form?**
□ **Yes** □ **No** **If yes, please provide:**

Name of Insured: _____ Name of Insurance Company: _____

Date of birth (dd/mm/yy): _____ Plan Policy Number: _____

Plan Member ID Number: _____ Plan Effective Date: _____

**Are you claiming any expense resulting from injuries or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law?** □ Yes □ No

**Does the person for whom you are submitting this claim have coverage through their Provincial Plan?** □ **Yes** □ **No**
**Provincial Plan Number _____ in the Province of _____.**

## Directions / Documents Required

Claim forms signed and dated, or they will be returned for completion.

Failure to answer all questions on this form will delay payment of your claim.

A paid receipt is required. Cash register receipts and debit receipts will not be accepted as a paid receipt.

A co-insurance statement of payment or denial is required if the claimant has co-insurance.

When assigning eligible benefits to the supplier, please complete the assignment of benefits on the second page of the form, and have the invoice attached.

Physician recommendations must be completed by the patient's attending physician and not the practitioner.

The physician's recommendation must be completed for all supplies and equipment.

The patient is responsible for securing this form and for any charges made for its completion.

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# Page 2 – Supplementary Health Expense

Supplies & Equipment

## Assignment Of Benefits To The Supplier

I hereby authorize the Administrator of the Electrical Industry Insurance Benefit Trust Fund of Alberta to issue payment of covered expenses relating to this claim directly to the supplier named on the invoice. **(Do not sign this section if you are attaching paid receipts.)**

_____

Signature of Plan Member Date (dd/mm/yy)

## Privacy Issues

I certify the charges for the medical supplies which are listed herein and for which the bills are attached were incurred by myself on account of myself or one of my eligible family members upon the recommendation and approval of the attending physician and required in connection with the medically necessary treatment of accidental bodily injury or sickness of myself or one of my eligible family members.

I hereby authorize the release of information contained in, or pertaining to this claim to the insurer, Plan Administrator, Medical Consultant, Trustees or any of their authorized representatives for purposes of settlement of this claim.

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Signature of Plan Member Date (dd/mm/yy)

## Section 2 - To Be Completed By The Attending Physician

Please **print** clearly: Patient's Name:_____

Attending Physician - Last Name, First Name and Initial:

Address: Postal Code: Telephone Number:

Date treatment commenced (dd/mm/yy): Expected duration of treatment:

Recommended Medical Item(s) Describe in detail.

Diagnosis of medical condition:

Specific reason for recommendation of medical item(s) including symptoms and physical findings.

Comments:

The appliance will be used for (check one): ☐ Daily Activity ☐ Sports Purposes ☐ Daily Activity and Sports Purposes

For replacement of a prosthesis, or other equipment, please provide: Date of Prior Placement _____(dd/mm/yy)

Reason for replacement: _____

Signature of Physician Date (dd/mm/yy)